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e. In cases where the rate appeal relates to an unresolved dispute between the hospital and its Medicare fiscal intermediary as to any cost reported in the hospital's base-year cost report, the Director will resolve such dispute for purposes of deciding the appeal.

f. The following matters will not be subject to appeal: (i) the use of statewide median, fiscal year 1988 costs to establish prospective per diem rates for the following levels of care: burn, neonatal intensive care, maternity, surgery, rehabilitation, psychiatric; (ii) the use of teaching or non-teaching status as the criteria for hospital peer groups; (iii) the use of medical school affiliation or Council of Teaching Hospitals membership as the criteria for teaching status; (iv) the use of peer-group-median, fiscal year 1988 costs to establish teaching hospital and non-teaching hospital per diem rates for the following levels of care: intensive/coronary care, routine care; (v) the use of fiscal year 1989 medical education costs to establish a hospital-specific medical education component of each hospital's prospective rate; (vi) use of the Data Resources, Inc. ("DRI") hospital market basket index (HCFA type) as the prospective escalator for operating and medical education costs; (vii) use of the Marshall Swift construction index as the prospective escalator for fixed-capital costs; (viii) use of a blended fixed-capital component of the reimbursement rate, according to the proportions specified in the reimbursement plan; (ix) the use of statewide median, fiscal year 1989 costs to establish the statewide portion of the blended fixed-capital component of the reimbursement rate, for both in-state and out-of-state hospitals; (x) the use of fiscal year 1989 per diem fixed-capital costs to establish the hospital-specific portion of the blended fixed-capital component of the reimbursement rate; (xi) payment of the neonatal intensive care level of care rate only to hospitals classified as Level III neonatal units based on criteria used by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey; (xii) the criteria used to classify claims into levels of care; and (xiii) the disproportionate share adjustment percentage established under the reimbursement plan.

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2. Burden of Proof and Factors to be Considered by the Department in Determining Whether to Grant a Rate Adjustment

a. The hospital shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this section must be calculable and auditable.

b. Except in cases where the basis for the hospital's appeal is limited to a claim that the rate-setting methodology or principles of reimbursement established under the reimbursement plan were incorrectly applied, or that incorrect or incomplete data or erroneous calculations were used in the establishment of the hospital's rate, the Department ordinarily will not award additional reimbursement to a hospital unless the hospital has demonstrated that the reimbursement it receives based on its prospective rate is less than the marginal cost it incurs in providing to title XIX Medicaid patients care and services that conform to applicable state and federal laws and quality and safety standards.

c. Notwithstanding paragraph 2(b), the Department may award additional reimbursement to a hospital that demonstrates by clear and convincing evidence that (i) the hospital's current prospective rate jeopardizes the hospital's long-term financial viability, and (ii) the Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are underreimbursed.

d. In determining whether to award additional reimbursement to a hospital that has made the showing required under sections (b) or (c) of this paragraph 2, the Director shall consider the factors and may take any of the actions described below.

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(i) The Director shall consider whether the hospital has demonstrated that its unreimbursed costs are generated by factors generally not shared by other hospitals in the state or in the hospital's peer group. Such factors may include, but are not limited to, the provision of atypical services, extraordinary circumstances beyond the control of the hospital, and improvements required to comply with licensing or accrediting standards. Where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures, the Director may deny the request for a rate adjustment.

(ii) The Director may consider, and may require the hospital to provide, financial data, including but not limited to financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation.

(iii) The Director shall consider whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

(iv) The Director may require that an on-site operational review of the hospital be conducted by the Department or its designee.

e. In awarding relief under these rules, the Director shall, as the Director finds appropriate, (i) make any necessary adjustments so as correctly to apply the rate-setting methodology, correctly to peer group the hospital submitting the appeal, or to correct calculations, data errors or omissions; (ii) increase one or more of the hospital's level of care rates or rate components by an amount that can reasonably be expected to cause the hospital's total Title XIX Medicaid reimbursement to meet the marginal cost that the hospital incurs in providing covered services to Title XIX Medicaid clients; (iii) increase one or more of the hospital's level of care rates or rate components by an amount that can reasonably be expected to ensure continuing access to

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sufficient inpatient hospital services of adequate quality for Title XIX Medicaid clients served by the hospital; or (iv) where rate relief is granted pursuant to paragraph 3 of these rules, increase one or more of the hospital's level of care rates or rate components by the amount required to meet the Medicaid share (to be determined on the basis of the hospital's Medicaid utilization percentage) of the net additional allowable costs incurred because of a catastrophic occurrence; provided, however, that in determining the amount of any adjustment, the Director shall take into account evidence of any cost-savings available to the hospital that would reduce its need for additional reimbursement, and may apply such potential savings as an offset to the adjustment amount.

f. Decisions by the Director to recognize omitted, additional or increased costs incurred by any hospital; to adjust the hospital-specific component of any hospital's rate; to change a hospital's peer group; or otherwise to award additional reimbursement to any hospital shall not result in any change in the statewide or peer group median until rebasing of the reimbursement system.

g. Rate adjustments granted under these rules (other than adjustments granted under paragraph 3) shall be effective from the first day of the rate period to which the hospital's appeal relates, shall continue in effect during subsequent rate periods until re-basing of the payment system, and shall be inflated by the applicable prospective escalator. However, no retroactive adjustments will be made to the rate or rates that were paid during any prior rate period.

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3. Catastrophic Occurrences

a. Nothing in paragraphs 1 and 2 shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Minor changes in cost patterns, circumstances that other hospitals have confronted without the need for a rate adjustment, and cost increases in excess of the prospective escalator normally will not be considered catastrophic occurrences.

b. In order to receive a rate adjustment under this paragraph, the hospital shall demonstrate that the catastrophe met the following criteria:

(i) one-time occurrence;

(ii) could not reasonably have been predicted;

(iii)not of an insurable nature;

(iv) not covered by federal or state disaster relief;

(v) not a result of malpractice, negligence, or a criminal act.

c. Any costs that the provider cites as a basis for relief under this section must be calculable and auditable.

d. If the provider believes its experience justifies continuation of rate relief in any subsequent rate year, it may submit subsequent requests for relief and information to update the information required under paragraph 1(c) within 30 days of receipt of the letter notifying it of its prospective rate for the subsequent rate year.

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D. Payment Adjustments to Disproportionate Share Hospitals

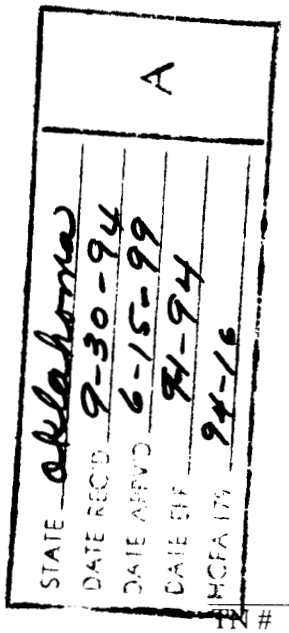
1. Eligibility Criteria

   a. A hospital shall be deemed a disproportionate share hospital (DSH) as defined by Section 1923(b)(2) or (3) of the Federal Social Security Act if: (1) the hospital's Medicaid inpatient utilization rate is a least one standard deviation above the mean Medicaid inpatient utilization rate for hospital's receiving Medicaid payments in the state; or (2) the hospital's low-income utilization rate exceeds 25%.

   b. In addition to meeting either of the above tests, there are two additional considerations: (1) a hospital must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid recipients. This requirement does not apply to children's hospitals or to hospitals, which, as of December 22, 1987 did not offer non-emergency obstetrical services to the general population. In the case of an urban hospital, (a hospital located in a MSA), an "obstetrician" is defined as any board certified obstetrician with staff privileges who performs non-emergency obstetrical services at the hospital. In the case of a rural hospital, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital. (2) A hospital must have a Medicaid inpatient utilization rate of not less than 1 percent.

2. Basis for Eligibility Determination

   a. For the period July 1, 1993 through September 30, 1994, survey information furnished by hospitals for their fiscal years ending during July 1, 1991 through June 30, 1992, will be used to determine eligibility under D. 1 above, and provide for disproportionate share payments. For subsequent Federal fiscal years, eligibility for disproportionate share payments will be determined annually by the State based on the survey completed by the hospitals. The survey must be received by the State each year by April 30. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year.



EXAMPLE:

Cost reporting periods ending:	1/1/94 through 12/31/94
Hospital surveys due:	4/30/95
For DSH payment year:	10/1/95 –9/30/96

b. For purposes of determining the mean Medicaid inpatient utilization rate, inpatient hospital days will be obtained from the most recently completed cost reports for those in-state providers not submitting surveys. Inpatient hospital days include newborn days, days in specialized wards, and administratively necessary days. They also include days attributable to individuals eligible for Medicaid in another state. They do not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs) or days which are attributable to services rendered in a separately licensed /certified entity.

c. Hospitals found to be ineligible for disproportionate share status upon audit shall be required to reimburse the agency for any disproportionate share payment adjustments paid for the period of ineligibility.

3. Payment Adjustment

a. Beginning the fourth quarter of Federal fiscal year 1993 and thereafter, DSH payment adjustments will be made on a quarterly basis. Beginning Federal fiscal year 1994 and thereafter, the total amount of DSH payments to eligible hospitals will equal the annual HCFA disproportionate share hospital amount allocated to the State.

b. Beginning with the quarterly DSH payments made in September 1994, DSH payments to individual hospitals (except for those hospitals qualifying for payments in the transition period as described below) will be equal to no more than one hundred (100%) percent of the hospital's uncompensated costs as defined below in 3.c., subject to the adjustment provision of 3.f. below.

A transition period for services from July 1, 1994 through June 30, 1995 is provided for high disproportionate share public hospitals as defined below. A public hospital may receive disproportionate share payments equal to two hundred (200%) of the hospital's uncompensated costs as defined below in 3.c., subject to the adjustment provision of 3. f. below. The Governor must certify to the Secretary of the Department of Health and

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Human Services that the hospital's DSH payments in excess of one hundred (100%) percent of the uncompensated costs are used for health services.

c. Definitions:

(1.) Public Hospital – A public hospital is one that is owned or operated by a State (or by an instrumentality or a unit of government within a state) as further defined in 1923(g) of the Act.

(2.) High Disproportionate Share Hospital – Public hospital that meets one of the following two categories: a) The hospital must have Medicaid utilization at least one standard deviation above the mean Medicaid utilization rate in the state; or b) the hospital must have the greatest number of Medicaid inpatient days of any hospital in the state, in the previous year.

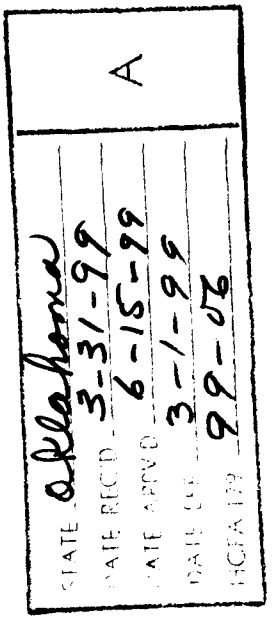
(3.) Uncompensated Costs (Basic Limit) – Uncompensated cost is the cost of furnishing inpatient and outpatient hospital services to Medicaid patients, net of Medicaid payments (excluding disproportionate share payments); costs associated with patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments paid by them.

(4.) Teaching Hospital – A licensed acute care hospital that has a medical school affiliation or belongs to the Council on Teaching Hospitals. A major teaching hospital has 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(5.) Public/Private Major Teaching Hospital – A major teaching hospital owned by the state that has entered into a joint operating agreement with a private hospital system.

d. Qualifying hospitals will be assigned to one of the following three pools for allocation of funds:

1. Public/Private Major Teaching Hospital
2. Other State Hospitals
3. Private Hospitals and out-of-state hospitals



e. Disproportionate share payment amounts for each respective pool shall be determined according to the following methodology:

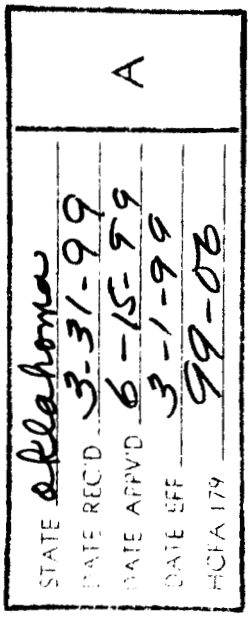
Step 1. The Medicaid revenue and imputed revenue for charity are totaled for each hospital qualifying for DSH adjustments.

Where applicable, revenue for charity will be imputed according to the following:

1.1. The average Medicaid per diem will be calculated by dividing the total inpatient revenue by Medicaid days.

1.2. The average Medicaid per diem will be multiplied by the reported charity days to arrive at "imputed" revenue for charity.

Step 2. A weight is assigned to each qualifying hospital by dividing each hospital's revenue total (Medicaid and charity) by the revenue total of the public/private major teaching hospital, which has the assigned weight of 1.0.
Step 3. A weighted value is then determined for each hospital by multiplying the hospital's assigned weight by the hospital's total Medicaid and charity revenue.
Step 4. The weighted values of all hospital's qualifying for DSH adjustments are totaled.
Step 5. The percentage of the public/private major teaching hospital's weighted value is determined in relation to the weighted values of all qualifying DSH hospitals.
Step 6. The weighted value of all state hospitals (except public/private major teaching hospital) are totaled.
Step 7. The weighted values of all private and out-of-state hospitals qualifying for DSH are totaled.
Step 8. The percentage of the total weighted values of the hospitals included in step 6 (state hospitals) is calculated in relation to the total weighted values (sum of Steps 6 and 7) of all remaining hospitals qualifying for DSH adjustment.
Step 9. The percentage of weighted values of the hospitals included in step 7 is calculated in relation to the total weighted values (sum of steps 6 and 7) of all remaining hospitals qualifying for DSH.
Step 10. The weighted percentages for the three hospital groups are next applied to the capped DSH amount allowed by HCFA for the Federal fiscal



year. The amount of DSH to be paid to the public/private major teaching hospital is determined by multiplying the state DSH allotment by the weighted percentage of the public/private major teaching hospital. The weighted percentage amount is then subtracted from the state DSH allotment. Once the public/private major teaching hospital's share of the state DSH allotment has been subtracted, the state hospitals' weighted percentage is applied to the remainder. The balance of the DSH allotment is distributed to hospitals in pool 3. Beginning with the DSH payments made in FFY96, the weighted percentage amount to be paid to the public/private major teaching hospital will not exceed 82.82%; the amount paid to the other state hospitals (pool 2) will not be less than 75.3%. Distribution of funds within each group will be made according to the relationship of each hospital's weighted value to the total weighted value of the group.

f. Disproportionate share payments shall not exceed the Federal disproportionate share State or other specific limits required by law. The OHCA shall make necessary downward adjustment to hospitals' DSH payments to remain within applicable limits. In the event it is necessary to reduce the amount of DSH payments to remain within the Federal DSH limit(s), the OHCA shall calculate a pro rata increase to all other qualifying hospitals in accordance with D.3.e.